

## **Abstract**

Early childhood practitioners, including speech-language pathologists (SLPs) frequently provide home practice to children and families. For children with speech sound disorders (SSD), who comprise a large proportion of SLPs' caseloads worldwide, completing home practice can increase the amount of intervention received and improve outcomes. However, little is known about parents' experiences of completing this home practice. The purpose of this qualitative study was to explore parents' experiences of completing home practice for children with SSD. Semi-structured interviews were conducted with six parents. Qualitative content analysis was used to analyze data and identify four themes: evolution over time, different roles, importance, and managing the practicalities of home practice. The findings speak to the complexities of this experience for families and the need for practitioners to collaborate with families when providing home practice. These findings have implications for the home practice that early intervention practitioners provide to children and families.

## Introduction

Worldwide, professional speech-language pathology associations recognize the important role that speech-language pathologists (SLPs) play in early intervention services (American Speech-Language-Hearing Association, 2008; Speech Pathology Australia, 2015). SLPs may work with children who have a range of different developmental concerns, including communication difficulties or problems with feeding or swallowing. SLPs work with a variety of children, including those with developmental language disorders, Down syndrome or Autism Spectrum Disorders. For many SLPs, however, much of their caseload is comprised of children with speech sound disorders (SSD; McLeod & Baker, 2014).

SSD is a common childhood communication disorder that may involve difficulty in one or more or more of the following areas: learning or producing speech sounds, syllables or the appropriate stress patterns in words; learning how to combine speech sounds in words to communicate meaning; and/or learning how to say words consistently in the same way. These difficulties can manifest in different ways, and so give rise to different subtypes of SSD. For example, children may have rule-based errors in their speech not typical for their age, such as a 4-year-old deleting one of two consonants from the beginning of words (e.g., saying *spoon* as “*poon*” and *please* as “*pease*”) or substituting more difficult speech sounds with easier speech sounds (e.g., replacing /s/ with /t/ and so saying *see* as “*tea*” and *sip* as “*tip*”). Rule-based speech errors are a normal part of speech sound acquisition; however, when the rule-based errors fail to disappear during early childhood a child is considered to have a phonological impairment. A different subtype of SSD is known as an inconsistent phonological disorder. Children with this subtype of SSD pronounce the same word in different ways (e.g., saying *shoe* alternately as “*Sue*,” “*zoo*” or correctly as “*shoe*”). A third type of SSD is an articulation impairment, that is, a difficulty learning how to physically pronounce specific speech sounds. Two common examples of articulation impairment

include the distortion or unclear production of “s” (i.e., a lisp) and “r”. In addition to phonological and articulation difficulties, two other types of SSD exist: childhood apraxia of speech and childhood dysarthria. Both of these subtypes of SSD are associated with motor speech control difficulties, and may be observed in some children with cerebral palsy (McLeod & Baker, 2017). Of the five types of SSD, phonological impairment is the most common (Broomfield & Dodd, 2004b). Each type of SSD can present as mild, moderate, or severe. For example, a child could have one speech sound in error or they could have multiple errors rendering their speech completely unintelligible. Children can also have more than one type of SSD, so they may present with articulation and phonological difficulties, or apraxia and phonological difficulties. The origin of an SSD for some children may be known, such as hearing loss, cleft palate or cerebral palsy; however, for most children with SSD, the origin or cause is unknown (McLeod & Baker, 2017). For many children without a diagnosed medical condition such as cleft palate the presence of an SSD may not become apparent until the child is two or three years old, when other children are becoming increasingly easier to understand.

A number of factors have been associated with an increased risk of SSD including: being male, having ongoing hearing problems, having a reactive temperament, and a positive family history of speech and/or language impairment (Fox, Dodd, & Howard, 2002; Harrison & McLeod, 2010). SSD is highly prevalent, with 15% to 16% of 3-year old children having the condition (Campbell et al., 2003). Children with SSD have an increased risk of future difficulties in learning to read, write and spell (Anthony et al., 2011; McLeod et al., 2017), and are more likely to be bullied than their typically developing peers (McCormack, Harrison, McLeod, & McAllister, 2011). In addition, long term outcome research has reported that by adulthood children with SSD “received lower grades in high school, required more remedial academic services throughout their school careers, and completed fewer years

of formal education” and “tended to occupy jobs considered semiskilled or unskilled with a much greater frequency than both the control subjects and their gender-matched siblings” (Felsenfeld, Broen, & McGue, 1994, p. 1341). To ensure that children with SSD have the best start to school life, it is important that they receive effective and timely early intervention before they start school (Nathan, Stackhouse, Goulandris, & Snowling, 2004).

In Australia, where this study was conducted, there is no piece of unifying legislation that mandates access to speech-language pathology intervention services for children (McLeod, Press, & Phelan, 2010). Although Australian children with developmental disabilities may be able to access funding for speech-language pathology services through schemes such as the recent and evolving National Disability Insurance Scheme (NDIS), not all children (such as those with less pervasive or medially-complex conditions) are automatically eligible to receive early intervention services through such a scheme. Unlike the US where the term *early intervention* may be used in a legal sense to refer to services provided to children from birth to age three (aligning with Part C of the Individuals with Disabilities Education Act), in Australia the term is used more broadly to refer to any intervention services provided to infants and young children (from birth to approximately seven years). This broad definition will be used throughout this paper. Children accessing early intervention services in Australia may have an identified condition impacting development such as cerebral palsy, autism, or hearing impairment, or they may have a single area of developmental concern such as speech without a concomitant medical condition or known cause. Regardless of the type or severity of developmental concerns, however, early intervention services are provided through the publicly-funded health or education sectors or through the non-government or private sectors. Although services in different countries may be accessed in different ways, research from both the US and Australia has found that

intervention for children with SSD is usually delivered by a qualified SLP (Brumbaugh & Smit, 2013; McLeod & Baker, 2014).

Research has shown that treatment to support children's speech development can be effective (Law, Garrett, & Nye, 2004), with various approaches for treating SSD in preschool-aged children available (Baker & McLeod, 2011). These approaches typically involve the SLP carefully analyzing a comprehensive sample of a child's speech to identify and prioritize specific speech errors to target in therapy, and then completing age-appropriate activities (e.g. card games, worksheets, craft, or puzzles) using pictures of words as stimuli to elicit target sounds—often in contrasting word pairs (e.g., *see,tea*; *sip,tip*; *sew,toe*; *sick,tick*)—with the child. Once the target word is elicited, the interventionist may provide feedback or cues to teach the child how to produce the target correctly and/or why it is important to use speech sounds in words to convey meaning (McLeod & Baker, 2017). Treatment for children aged three to six—corresponding to the broad definition of early intervention used in this paper—is typically delivered individually or in small groups in clinic or preschool settings (Brumbaugh & Smit, 2013; McLeod & Baker, 2014). Research evidence shows that services need to be delivered frequently in order to be most effective, ideally three therapy sessions per week (Allen, 2013). However, surveys of SLPs' service delivery suggest frequent sessions are not routine practice (Sugden, Baker, Munro, Williams, & Trivette, 2018; Brumbaugh & Smit, 2013). Barriers to service delivery—such as insufficient funding and increased demand for services (Speech Pathology Australia, 2014)—limit the amount of intervention available to children with SSD. These barriers have consequences for the effectiveness of intervention services as well as the long-term outcomes for these children. One solution favored by SLPs is to involve families as a way of increasing the intensity of intervention delivered to children (Sugden, Baker, Munro, Williams, & Trivette, 2017).

Involving families in services is seen as best practice within the field of early intervention, aligning with principles of family-centered practice (Division for Early Childhood, 2014) and the principles of professional speech-language pathology associations (e.g., American Speech-Language-Hearing Association, 2008). For SLPs working with children with SSD, family involvement in intervention is common practice. The majority of Australian SLPs (96.4%) who responded to a survey reported to involve parents in intervention, most commonly in delivering home practice activities (Sugden et al., 2017). These home practice activities typically involved the child producing target sounds or words in games or activities (such as a memory card game in which the child says the words as they turn over a card), the parent correcting the child's erroneous productions of words in everyday conversation, completing worksheets (in which the child has to say targets sounds or words a pre-determined number of times), or integrating practice into everyday routines (Sugden et al., 2017). These home practice activities are usually recommended to be completed 5 to 7 times per week, and last for 5 to 15 minutes. SLPs reported training parents to deliver the home practice, most often through direct observation of the SLP. Although the SLPs who completed this survey believed that home practice is an essential part of intervention for children with SSD, they reported many challenges including low completion rates and incorrect implementation by parents (Sugden et al., 2017). These barriers may limit the success of home practice, which in turn may reduce intervention outcomes for children with SSD. A deeper understanding of these barriers is therefore imperative, which can only be gained through an explicit exploration of parents' experiences.

To the authors' knowledge, only one study has explicitly investigated parents' experiences of being involved in intervention for their child's SSD. Watts Pappas and colleagues (2016) interviewed 7 parents of 6 children with SSD. These parents viewed their involvement as an important part of intervention, but they felt it was the SLPs' role to work

with the child within sessions while the parents would “actively observe the treatment sessions and work with [their] child at home” (Watts Pappas et al., 2016, p. 231). These findings have parallels with other research that has explored parents’ experiences of being involved in intervention for other communication disorders. These studies have shown that parents have a general expectation that the SLP will be the primary decision-maker in intervention who will take the lead in delivering intervention, but that parents would support the intervention at home (Carroll, 2010; Glogowska & Campbell, 2000; Lyons, O'Malley, O'Connor, & Monaghan, 2010). Watts Pappas and her colleagues (2016) concluded that the nature of a child’s disability may influence parents’ expectations about being involved in intervention, with parents of children with less pervasive developmental disabilities (such as SSD) perhaps being more willing to participate in home practice activities.

Although being the first study to explore parents’ experiences of being involved in intervention for SSD, the study by Watts Pappas et al. (2016) did not focus on parents’ experiences of the most common way that they are involved in their child’s intervention: completing home practice. The Division for Early Childhood (DEC) recommended practices state that early intervention providers—such as SLPs working with children with SSD—should consider family preferences when working with children (Division for Early Childhood, 2014). Currently, however, there is no literature investigating parents’ experiences of and preferences for being involved in their child’s home practice. The research presented in this paper addresses this gap.

Given that this research aimed to explore lived experiences, the use of qualitative methods was deemed the most appropriate. Using qualitative methods enables researchers and practitioners to identify ways in which interventions and service delivery models (such as the provision of home practice) could be best tailored to meet the needs of families, by exploring their personal experiences and stories. The primary research question was: how do

parents of children with SSD experience completing home practice activities aimed at treating SSD? Although specific to SSD, the information gained through this study may help other early intervention practitioners who provide home practice to other children with less pervasive or medically complex disabilities.

## **Method**

### *Approach*

An interpretivist constructivist paradigm was used to guide decisions related to data collection and analysis for this study. This paradigm aims to understand the experiences of people and recognizes that people who share in the experience of a phenomenon may have similar perceptions of the experience (Ponterotto, 2005). The participants in this study share the background of being parents of children with SSD who have been involved in completing home practice for their child. Thus, a constructivist approach was appropriate to guide the research as, while the participants have a shared experience, they may have their own experiences relative to the individual nature of their children and their family.

### *Recruitment*

Parents of children aged 3-6 years who had seen an SLP for treatment of their child's SSD within the previous 12 months were recruited. This age range was selected as it is the most common age of children accessing services for SSD in Australia (Sugden et al., 2017).

Participants were recruited from metropolitan areas of Sydney, Australia. Flyers about the study were posted on parent-specific social media pages, local speech-language pathology clinics, independent preschools and day-cares, the University of Sydney's Faculty of Health Sciences' research recruitment website, and sent to SLP graduates from the University to distribute to potential participants. A total of seven parents expressed an interest in participating in the study. Of these, one was unable to commit time to participate and the



remaining six participants were included in the study. Recruitment of new participants ceased once the research team identified that data saturation had occurred.

## *Participants*

Table 1 presents information about the participants. Pseudonyms are used throughout. All participants were mothers who had a child who was either currently receiving intervention for SSD, or who had received intervention within the previous 12 months. All participants reported that intervention was delivered in clinic environments, reflecting typical service delivery models used in Australia (Sugden et al., 2018). To ensure confidentiality of SLPs, participants were asked not to name the specific service through which they accessed speech pathology support. Based on the demographic information collected and geographic distribution of participants, it is unlikely that any participants had seen the same SLP. Two participants (Jane and Diana) had more than one child who were either currently or had previously seen an SLP for SSD. Given that the focus of the study was on children aged 3-6 years, these participants were asked to focus the interview on their experience of their child within this age range. However, in their discussions of their experiences, these parents raised their experiences of being involved in all of their children's intervention services. When this occurred, the interviewer re-directed the parents. Participants' socioeconomic status was determined using the Index of Relative Socioeconomic Advantage and Disadvantage (IRSAD; Australian Bureau of Statistics, 2011), which is based on the geographical area where the participants lived.

## *Data Collection*

Interview questions were developed by the researchers and piloted with three parents of children with SSD prior to the study. The semi-structured interview protocol is presented in Appendix A. The protocol contained broad main questions (for example: *how would you*

*describe the experience of doing home activities for yourself and for your child?*), as well as probing and follow-up questions to elicit additional detail or depth of responses from participants. Additionally, parents were asked to describe the home practice activities they were provided by their SLP. Ethical approval from the University of Sydney was gained for this study (project number 2015/723).

All interviews were conducted by the first author, who was trained in interview techniques. As part of this training, the third and fifth authors observed at least one of the pilot interviews and provided feedback on the first author's use of interview techniques. Transcripts of these pilot interviews were also examined by the second author who provided additional feedback.

Interviews were conducted from January 2016 to January 2017. The interviews were conducted in one of three places: at the participants' home, at the participants' workplace, or at the University of Sydney's speech-language pathology clinic. For five of the six interviews, only the participant and interviewer were present; however, the final interview (with Daphne) was conducted during school holidays at the participant's home; this interview was interrupted on several occasions by her two children.

The interviews ranged from 40 to 75 minutes in duration and were audio recorded using two digital voice recorders. Recording commenced after gaining signed informed consent, collection of demographic information and completion of the Intelligibility in Context Scale (ICS; McLeod, Harrison, & McCormack, 2012a).

The ICS is a 7-item parent-reported measure of children's speech intelligibility that rates the degree (from *always* to *never*) that a child is understood by a range of listeners, including parents, immediate family members, teachers and strangers. Higher scores (ranging from 1 to 5) indicate that the child is more easily understood by a range of listeners (McLeod, Harrison, & McCormack, 2012b). Scores on the ICS are correlated with performance on

established and valid direct assessments of children's speech severity (McLeod, Crowe, & Shahaeian, 2015). In this study, the ICS served as a proxy measure for the presence of each child's SSD as direct assessment was not possible due to scheduling conflicts and ethical approvals.

Following each interview, the first author recorded observations, initial interpretations, and field notes in a notebook. These were then discussed with the research team. Interviews were transcribed verbatim into Microsoft Word ® 2010 by the first author, who subsequently reviewed each transcript while listening to the audio recording to ensure accuracy of transcriptions.

## *Analysis*

Interview transcripts were analyzed using the Qualitative Content Analysis protocol described by Graneheim and Lundman (2004). This focused on the latent level of interpretation, in which the underlying meaning of the text is analyzed. Qualitative Content Analysis was deemed an appropriate technique for analyzing the interview data, as it stays close to participants' words while simultaneously summarizing the data and underlying meanings. In the first stage of analysis, text relevant to the research aims was identified and labelled as meaning units. These meaning units were phrases, sentences or paragraphs spoken by the parent, and excluded conversational fillers and unrelated humor. In the second stage of analysis, these meaning units were then condensed using words that closely approximated the participants' words. This was conducted by the first author, and the second author confirmed the condensed meaning units as being accurate representations of the participant's words. In the third stage of analysis, the condensed meaning units were interpreted to form codes. Again, this was conducted by the first author and was confirmed by the second author. The fourth stage of analysis involved grouping codes into mutually exclusive categories based on shared meaning. This was conducted jointly by the first and second authors. Finally, themes

were developed that connected the underlying meaning of categories. The first, second and fourth author developed themes, which were checked by the third author. An example of the first three stages of the analysis process is shown in Table 2.

### *Credibility and Trustworthiness of Data*

Several measures were taken to address the credibility and trustworthiness of the research data and findings. First, member checking was completed after the interviews were transcribed (Creswell, 2013; Houghton, Casey, Shaw, & Murphy, 2013). Participants were invited to review their transcript and the initial interpretations of their data. No participants requested that changes be made to these interpretations. Second, the selection of suitable meaning units for analysis—an important issue for trustworthiness—incorporated a two-step process with meaning units initially identified by the first author subsequently agreed upon by the second author. Third, codes and resultant themes were determined through consensus between the first four authors, which allowed for convergence of opinions from multiple members of the research team. Additionally, field notes were completed following each interview and included information, observations and initial interpretations regarding the content of the interview, which were shared with other members of the research team. An audit trail of decision-making relating to identifying, condensing and interpreting text was maintained. Collectively, these processes of peer-checking and peer debriefing (in conjunction with field notes and use of an audit trail for Qualitative Content Analysis) are recommended strategies for increasing the credibility and trustworthiness of qualitative data (Elo et al., 2014; Houghton et al., 2013; Vaismoradi, Turunen, & Bondas, 2013).

### *Researchers*

At the time of the study, the first author was a certified SLP enrolled in a PhD program. The second and fourth authors both held PhDs and were senior lecturers and certified SLPs. The third author, who held a PhD, was an associate professor and early childhood educator with

research interests in engaging and empowering parents who received early intervention home-based services. The fifth author was a professor, certified SLP and associate dean, with research interests in SSD. These backgrounds may have influenced interpretation of the data, as well as the participants' interactions with the interviewer, as they were aware that the interviewer was a qualified SLP (Bishop & Shepherd, 2011).

## **Findings**

The participants reported being given different types of home practice activities by their SLP. These included routines-based activities (e.g. activities that were designed to be embedded into everyday activities, such as saying words when cooking or gardening, or correcting their child's speech in daily conversation) and structured activities (e.g. activities requiring resources, such as worksheets or games, that required specific resources to be used for several minutes at a time). All participants reported receiving both types of activities; however, the specific activities varied across participants.

Analysis generated four key themes: *evolution over time*, *different roles*, *importance* and *managing the practicalities of home practice*. A summary of the themes is listed in Table 3. Although the four themes represent distinct aspects of parents' experiences, they are connected and interact with each other at many levels. This interconnectedness, presented in Figure 1, speaks to the complexity of parents' experiences of being involved in their child's home practice. Each theme interacts with other themes to mediate parents' experiences of completing home practice for SSD. The themes will now be explored and illustrated with example quotes from participants.

### ***Theme 1: Evolution over Time***

All participants in this study spoke of a process of change relating to home practice. Parents spoke of changes in four areas: ability, expectations, experiences and emotions.

**Ability.** Parents discussed changes in ability both in terms of their own ability to complete home practice, as well as their child's abilities. Regarding their own abilities, parents said that initially they found home practice activities difficult to complete, and that they were "*a lot to get your head around at first*" (Margaret). However, parents perceived that their abilities regarding completing home practice changed and evolved, until they felt that "*it's easy now*" (Agatha).

In addition, parents reported that their ability to complete home practice changed over the course of intervention. One participant, Agatha, mentioned that she initially asked her SLPs to not provide much practice for home as she felt that she would be unable to complete it; however, Agatha felt that she would be able to complete it now "*even if they gave a bit more.*" In addition, parents suggested that completing home practice had positively influenced their ability to interact with their child. Two parents (Joanne and Daphne) mentioned that they now felt more confident and able to praise their children, and that this had generalized to other areas of parenting, not just speech:

*I find it's easier for me, more natural for me now, to comment on "oh, you couldn't do that before and now you can, you've been working really hard," and that's a really nice side-effect that's come out of it for me, just being able to see that and knowing how to respond to that. (Joanne)*

Parents also spoke about how their child's abilities changed as they have gone through speech pathology services and completed home practice activities. Parents commented that completing home practice had a positive impact on their child's communication, as stated by Agatha: "*When I was doing the homework I could see the improvements that she [the child] was making.*"

Parents felt that improvements in communication abilities changed other areas of the child's life, such as behavior and confidence. Daphne said "*you know, so she goes from being*

*frustrated and not bothering to talk because nobody understands her, to being someone that, even if she does make mistakes, she's... she's much more confident."*

**Expectations.** Participants discussed how their expectations of intervention and home practice evolved over time. Prior to starting intervention, some parents had not considered what intervention would be like, as stated by Joanne: *"just because I hadn't thought about what it might be like before, but it made sense in the end."*

One parent expanded on this process of change by recollecting her initial expectations of speech-language pathology intervention. Agatha said that parents, generally, think that if they see a SLP then the SLP will *"sort it out."* She said that *"that's what my initial mentality [was], but it's not like that."* Another parent, Daphne, had a similar change in her expectations of intervention: *"I think, well, after the first session I kind of realized that it's actually more at home. When you're only going every second week... it's actually more at home."*

**Experiences.** Parents spoke about how their child's experiences, as well as their own, had evolved. For Joanne, the experience of completing home practice was initially filled with doubt: *"I think the idea of doing the therapy at home was a bit daunting for me."* However, her experiences evolved as she completed more intervention and home practice, so that *"gradually it became easier, and so... um... certainly now I feel very comfortable doing [it]."* This was an experience shared by many of the parents, who spoke about how they initially experienced home practice to be overwhelming but that they *"don't see a problem with it now"* (Agatha).

In terms of their child's experiences, the parents said that initially their child found it hard to complete home practice. Children were sometimes frustrated when asked to complete

home practice, with Daphne mentioning that her daughter initially had negative emotional reactions when they were practicing her speech sounds. Daphne said: *“at the start, if I said ‘no, that’s wrong’, she would have cried.”* However, the parents stated that their children’s experience of home practice changed over time. Margaret spoke about how her son’s experience of home practice has changed as his ability has improved: *“but I think that as he’s seen the improvement, he really wants to talk, so I think he can see the benefits now so he’s more engaged in it.”*

**Emotions.** This subtheme represents parents’ changing emotions over the course of intervention. As stated by Jane, being involved in completing home practice is *“an emotional journey.”* The parents said that the initial steps to getting help were overwhelming. Daphne recounted how she initially sought help for her daughter’s speech:

*I just walked past the chemist [drugstore] one day and they had a nurse in there, so I just said “oh, you know, my daughter’s not too bad, these are the things she does” and she [the nurse] said “that doesn’t sound right”, but then the next steps are quite full on. Like, going to a doctor, going to a pediatrician, everyone’s telling me there’s stuff wrong.*

For some parents, these emotions also extended into completing home practice. Margaret, whose son had been diagnosed with a severe SSD, spoke about how seeing their child’s progress helped her and her husband to become less stressed and worried:

*I think at the start, because we were... so worried about him, I think... it’s a severe speech sound disorder and we were like, stressed about it, as you are, I think there was a lot of pressure then, and... So that was a bit stressful at first but once we could see the progress... we’ve been a little more relaxed about it.*



One parent also spoke about how her emotions about her child's speech interfered with her completion of the home practice. Joanne said that "*parental pride*" meant that it took a long time for her to be convinced that her child needed to see a SLP, and that she "*was pretty reluctant at first to put the effort into it that [she] should have put into it.*" However, like Margaret, Joanne's emotions changed as she saw her son make progress:

*I think once I started to see the results it was a bit more clear that there had been a problem and that the therapy would actually do something... and once people started commenting on how they could understand him more easily... at that point I became more dedicated I guess.*

These emotions experienced by parents continued to change after parents had completed therapy. Joanne, whose son had been discharged from community-based speech-language pathology services, expressed regret and guilt that she had not completed all the home practice activities:

*Harry would have improved faster if I had done the amount of homework that she [the SLP] told me to do... He did improve, and he showed definite signs of improvement every week, but they weren't as rapid as they could have been because I wasn't putting in the effort. (Joanne)*

## ***Theme 2: Different Roles***

This theme explored the different roles that people play in the intervention process. The idea of roles encapsulates both specific responsibilities attributed to each person, as well as the inter-personal relationships present in the therapeutic process.

***Responsibilities.*** Participants spoke about the different responsibilities they had in their role as a parent, as well as the responsibilities of the SLP. An interesting finding was that parents saw completing home practice as their responsibility: parents spoke about how, because they

are with their child frequently, they were able to complete regular home practice. This sentiment was echoed by all parents, as illustrated by Margaret: *“I guess because I’m with him all the time and I’m the one that can do it with him at home, whereas we’re only sort of seeing a speech pathologist once for an hour every three weeks.”*

As well as doing home practice, many parents identified that it was also their responsibility to work with their child within the clinic-based sessions with their SLP. For example, Daphne said that *“I think you get better value”* by being directly involved in sessions, and reflected on the differences between observing sessions and being actively involved by saying *“and I think if you were just watching, you wouldn’t pick up on that at all.”* However, other parents preferred observing the SLP working with their child. For example, Agatha said that she left the sessions to their SLP because she didn’t *“want to overstep the line.”* Jane commented about how it is the SLPs’ responsibility to provide a high dosage of intervention within a session, as this is what helps children learn. She said, *“can I use you [SLP] for that 30 minutes because it’s very precious. And then at least I’m getting 100% rate [from the SLP], and I’m doing 50% rate [at home], and I can keep doing it.”*

Parents also saw the responsibility of advocating for their child to be part of their role. Jane, whose son Darcy has a severe SSD, and had recently started school, spoke about difficulties in coordinating speech-language pathology services with her son’s school. She said that teachers did not always understand the link between speech and literacy development, and that she was often trying to *“bridge the gap”* between the school and her SLP. She saw this as an integral part of her role as Darcy’s parent, by saying *“I see myself as a very big advocate for Darcy, and I will fight for him.”*

Although Jane had a clearly defined notion of her responsibilities in relation to her son’s intervention and home practice, many parents were not so clear on their role. Several parents spoke about how they had not discussed their level of involvement in intervention and

home practice with their SLP. Rather, these parents said that they “*just fell into*” (Agatha) the role of doing home practice. These parents also spoke about how their SLP had expectations about the parents’ role in home practice, and that this was not always discussed, as stated by Joanne: “*I’m not sure it was a discussion as much as this is what you need to do.*”

Although their responsibilities were not always made clear to them, parents felt that it was their responsibility to help their child meet developmental milestones. This is stated by Joanne, who also mentioned that she expects to help out at home when her son starts school, for example: “*my personal view of parenting is that it is the parent’s responsibility to make sure that your child does what children need to do and learns what children need to learn.*”

Two parents spoke about how their role and responsibility is more important than the SLPs’, and how the SLP is a “*tool to use*” who can “*give you the tools to use at home*” (Diana) to help their children. Margaret said:

*When they’re as young as Jimmy is [3 years old], I think that the parent’s role is more important than the speech pathologist’s. I mean, we can’t do it, obviously, without the direction of a speech pathologist but you’re [the parent] the one engaging with the child on a daily basis. So it’s really up to you to be encouraging it as much as you can.*

Although parents saw their role as integral to their child’s speech therapy, the parents who were interviewed in this study also identified responsibilities that were specific to the SLP. For example, the parents discussed how it was the SLP’s responsibility to educate parents about SSD and “*the types of things that [their] child might struggle with*” (Daphne). Parents viewed the SLP as being responsible for leading intervention and instructing parents what to do at home. Diana said “*I’m here for the kids. Whatever they tell me to do I’ll do.*”

Parents also said that they needed the SLP to provide reassurance regarding home practice, for example: “*being reassured that actually it was easy things and that I would be*

*told how to do them and if I didn't understand I could ask questions"* (Joanne). Parents also spoke about how it is the SLP's responsibility to make home practice easy for parents to complete by providing materials and resources.

**Relationships.** Many different types of relationships were raised in the interviews. These encompassed *bonds* as well as *networks*. These dimensions are delineated below.

**Bonds.** Completing home practice was seen to influence, or be influenced by, several different bonds. Several parents spoke about how completing home practice was positive for their relationship with their child, as stated by Joanne: *"in some ways it forced me to spend really good time with him, and kind of regularly, and that was really nice and I think really helpful as just kind of a bonding sort of thing."*

Parents also spoke about how the bond shared by their child and the SLP motivated their child to complete home practice. This idea is illustrated by Jane, whose son was motivated by his SLP, for example: *"he now trusts her, so it's great when I come back home because I'm like 'we need to do this for her' and he will do it because she motivates him and she drives him and she's just brilliant."*

Regarding the bond between their child and the SLP, parents also commented on the need for SLPs and children to have their own positive relationship. Jane, whose children had seen several SLPs over the past few years, commented on the need for the SLP and the child to match, *"and she [previous SLP] was brilliant for Emma [older daughter] ... She was just amazing. She was just warm... but she was not the right match for my son."*

**Networks.** The parents who were interviewed in this study discussed how their child and home practice fitted in within wider networks, such as a family and a community. Several parents mentioned how their whole family became involved in home practice, including siblings, grandparents and the other parent. For example, Margaret spoke about

how involving her wider family had made it easier to stay motivated and complete home practice with her son:

*And probably because we have engaged our wider family so they're always asking 'how's he going' and that, so it helps push it along. Because there's more than, it's not just all on me, like the husband and the family help as well.*

One mother, Jane, spoke about the struggles of completing home practice when her extended family network was not involved or supportive. In contrast to Margaret, Jane felt quite isolated. When asked about her overall experience of completing home practice with her son, she said it was “*lonely*.” However, Jane had sought support from an online network of parents of children with SSD. She said that she was part of Facebook support groups, and this had helped her with home practice and with the emotional journey of being a parent of a child with SSD.

### *Theme 3: Importance*

Throughout the interviews, parents spoke of things that were important to them.

***Speech is important.*** Parents spoke about the importance of being able to speak clearly. The parents valued the role that communication plays in education. Many parents were concerned about the link between SSD and literacy development, and felt that speech is “*a life skill. And it's going to help them in everything. It's going to help them in their school work*” (Daphne). Additionally, parents felt that having age-appropriate speech was important for developing social skills and friendships. Diana related a story about her youngest son, Jamie, who had struggled to make friends in preschool because of his delayed speech:

*I think with Jamie and how his speech is delayed, he didn't develop a friendship with people until, not much later... until he was four, and the other kids at his group were*

*already forming friendships with each other. They were able to play and pass toys and things like that. He [Jamie] was mistaken for snatching.*

Thus, parents valued the role that speech plays in a child's education, literacy and social development.

***Parent involvement is important.*** Parents also valued their role in the intervention process.

Jane epitomized this subtheme by saying *"the parent's role is really important."* This subtheme is linked to previous discussions around the parent's roles in intervention. Parents felt it was important that they knew what was going on in their child's speech-language pathology intervention, and that they were able to help.

***Home practice is important.*** Parents also valued home practice, and spoke about the positive impacts it had on their child's speech. Parents recognized that speech is a skill that needs frequent practice, *"I think it is a good idea because they need to like, they need to constantly be practicing"* (Agatha). Parents also mentioned that home practice was helpful for their child's learning and speech development. Daphne said that completing home practice *"makes heaps of difference, like it really does."*

***Rapport is important.*** Rapport between the child and the SLP, as well as the parent and the SLP, were seen as important by parents. Parents valued SLPs who had a positive alliance with their child, for example by saying *"and she's really built a rapport with him which is nice"* (Margaret). Jane extended on this by listing some characteristics of her current SLP that helped in building an alliance: *"she can read him. She knows when he's struggling but yet she pushes him. She's very good. She won't say unrealistic things to him."*

Parents felt that this rapport was important, as it motivated children to complete home practice and be engaged in intervention. Parents also commented on the valuable nature of their own rapport with their SLP, and how this influenced their own response to intervention. Parents valued SLPs who put effort into building this working alliance. For example, Jane felt “*it was really important that they were listening to me*” about her goals for her child and what she “*can and can’t do*” for homework. Joanne commented on the importance of SLPs’ understanding how busy family life can be, and how this impacts on the completion of home practice:

*The weeks that I struggled to get the therapy done—either because life was busy or because Harry [son] was just not interested—I always felt very able to tell [the SLP] that we’d had a bad week and she was very understanding.*

Parents also valued SLPs who tailored intervention to suit them and their family, which is an important component of building therapeutic rapport. Agatha, when talking about her experiences with previous SLPs, described being given home practice activities to complete with her daughter while cooking: “*coz I don’t cook at home. So they were saying to me, ‘do this while you’re cooking’—I can’t.*”

Other parents spoke of the importance of having home practice activities that considered the whole family, as well as the individual child’s strengths and weaknesses. For example, Jane spoke about how difficult it was when SLPs didn’t consider the whole context of her family and provided unreasonable suggestions:

*This frustrated me. When a speech pathologist said to me... “use every opportunity [to practice speech]. Use the car as an opportunity”. And I went “um.... I can’t understand my son in the car”. I said, “I’m concentrating on the road, I’ll have Emma and Elizabeth [older children] in the car, that’s not a chance for me to talk.”*

## *Theme 4: Managing the Practicalities of Home Practice*

The final theme revolves around managing the practicalities of home practice. All parents who participated in this study spoke of challenges to completing home practice, and ways that they had problem-solved these to suit their own child and family

***Logistics of home practice.*** One key aspect that required management from parents was the logistics of doing the home practice. All parents spoke about how they were busy and it was often a challenge to fit home practice in. When asked what the biggest challenge she faced in completing home practice, Diana said that it is a “*time factor... it really is the time factor.*” In addition to the challenge of finding the time, parents spoke of challenges in scheduling home practice around other family commitments, for example “*I felt... I had a newborn baby. Harry was at preschool a couple of days a week, and I found it really hard on preschool days to do the therapy because he’d come home at the end of the days tired*” (Joanne).

Parents also spoke about how their child’s behavior and response to home practice influenced the logistics of completing home practice.

*If I do it with Darcy I’m like “am I going to have a battle? Am I then going to have a half hour tantrum? Am I ready for that?” ... And that’s where I’d go... actually, no, I’m not, because we’re about to go to swimming, we’re about to do that, I’m going to have to leave it til later, because if he did have a meltdown, then I’m carrying a child out screaming to the car* (Jane).

Parents spoke about how they had managed home practice to make the logistics easier. Diana, who had three children, explained that all of her children completed their speech-language pathology home practice and school homework together so that no-one felt left out:



*Everyone is there together and doing their own different thing. Like I said, they're all on to three different levels, and you manage to sort of peek over and say "this is what you do" so, we sit them all on the dining table...*

However, even with these problem-solving strategies, most parents spoke about how they did not complete the amount of home practice that they were assigned by their SLP. An interesting finding was that some parents preferred home practice activities that fit into their daily routines, whereas others preferred the more structured activities.

**Readiness for home practice.** Readiness for home practice refers to both the child's readiness and the parent's readiness to complete activities. Parents said that completing some activities *"depends what sort of mood he's in. Like if he's in a mood where he just doesn't want to do it like, like 'not ready yet mum'"* (Diana). The parent's mood also appeared to influence whether and when parents were able to complete home practice. Agatha commented that parents needed to be in the right mood to complete activities with their children: *"and to be honest, in the morning, especially if I haven't got my coffee..."*

Parents also commented that motivation was an important component of being ready to complete home practice. Joanne said that *"keeping Harry motivated to do it, and keeping myself motivated to do it was hard and stressful..."*

**Activities.** Parents discussed the activities that they were asked to complete for home practice. Some of the activities parents were provided with did not suit their children or their family: Jane described being provided with a speech activity that required her son to cut and paste:

*He had some parts that he needed to cut out, like boxes that he needed to stick on—we didn't do that, coz he had problems on fine motor. And I thought, by the time he cuts it*

*out, that's the task, by the time he sticks it on, I thought... for something that's maybe a minute worth of [practice]... (Jane)*

However, as well as being provided with activities that did not suit their children, some parents spoke about how the activities were fun and engaging, and how this was important. For example, Diana said that “*the boys think they're fun*” when asked about the tasks they completed for home practice. Parents also spoke about how they adapted the activities they were provided to suit their child's interests.

**Knowing what to do.** For parents, knowing what to do for home practice included both knowing what activities to complete and knowing the technical skills of intervention. Parents spoke about how they were often asked to repeat activities that the SLP had run in their clinic-based sessions, but that this was sometimes challenging “*because you forget really easily what you did in a session and especially a few days later*” (Margaret).

The time between scheduled sessions and the lack of clear instructions for home practice were challenges for many parents trying to complete home practice. In addition, most parents commented that they were unsure how to teach their child at home, particularly after their child had said a target word or sound incorrectly:

*And when [the SLP] did it in the sessions, it all seemed very simple... And then I'd try to do it at home and I couldn't work out how to explain it to him so that he would get his tongue in the right place. (Joanne)*

To overcome these challenges, one parent (Daphne) suggested that SLPs could provide parents with a “*run-sheet*” for home practice. Daphne suggested that this could include a list of what to complete for home practice, how often, and “*tips and tricks*” for how to help their child achieve success.

## *Example Interactions between Themes*

As mentioned above, the four themes identified within the study interact with each other to mediate parents' experiences of completing home practice (depicted in Figure 1). This interaction may occur in many ways. As an example, the first theme of *evolution over time* can interact with theme two (*different roles*) by changing parents' perceptions of each person's role. As parents' abilities, expectations, experiences and emotions change over time, so too do the roles that they and their SLP play in home practice. Specifically, the parents who participated in this study identified that it was the SLP's role to provide reassurance regarding home practice: as parents' emotions about home practice change, this may influence how the SLP manages this aspect of their role, which in turn may support parents in *managing the practicalities of home practice*. Further, the parents who participated in this study placed *importance* on the rapport between the SLP, their child, and themselves. Positive rapport was mentioned as motivating children to participate in home practice activities, which again influences parents in *managing the practicalities of home practice*.

## **Discussion**

In this study, we sought to understand parents' experiences of being involved in their child's home practice for SSD intervention. We identified four themes that encompassed the experiences of six parents of children with SSD: *evolution over time*, *different roles*, *importance*, and *managing the practicalities of home practice*. These themes, although distinct, interacted to shape parents' experiences of completing home practice. In addition, the four themes were consistent with themes in the literature regarding parent involvement in intervention and completion of home practice, both specifically to speech-language pathology and with the wider field of preschool early intervention. The findings from this study have implications for how early intervention practitioners work with children and their families.

## *Comparisons with the Literature*

One key finding from this study—that of evolution and change over time—has links with previous research exploring parents’ experiences of being involved in intervention and completing home practice. Previous researchers have reported that parents’ expectations about their level of involvement in early speech and language intervention, as well as their conception of their role, change as they experience intervention services (Davies, Marshall, Brown, & Goldbart, 2017; Watts Pappas et al., 2016). Indeed, similar to the present study, other researchers have found that parents view intervention and home practice as improving their child’s abilities and confidence as well as positively impacting on their relationship with their child (Goodhue, Onslow, Quine, O’Brian, & Hearne, 2010). Other parents, like those who participated in this study, have reported feelings of guilt about completing home practice (Goodhue et al., 2010; Marshall & Goldbart, 2008). However, a recent study that explored parents’ experience of providing intervention at home for their child with childhood apraxia of speech, a rare but severe subtype of SSD, reported conflicting findings. These parents reported experiencing negative emotions about completing home practice with their child (Thomas, McCabe, Ballard, & Bricker-Katz, 2017). Combining these findings shows that being involved in intervention and completing home practice can be a transformational experience for parents. The parents who participated in the current study emphasized the importance that support plays in this journey.

One source of support for parents accessing early intervention services is their early intervention practitioner (Kruijsen-Terpstra et al., 2014). Parents of children accessing early intervention have reported that their feelings “of positive personal relationships with treatment team members appeared to validate parent concerns, facilitate feelings of support, and contribute to their overall experiences” and evaluation of the service (Freuler et al., 2014, p. 524). The parents who participated in the current study viewed it as the SLPs’ role to be a

source of support. These parents valued SLPs who took the time to develop a relationship with their family, and who was understanding of obstacles to completing home practice. In addition to this aspect of the SLPs' role in intervention, the parents spoke about other roles that members of the intervention team played.

The parents who were interviewed in this study commented that it was their responsibility to deliver home practice, but that this would be directed and guided by their SLP. They viewed the SLP as the expert, who would take a leading role in decision-making and planning intervention. These different roles and responsibilities align with the findings of previous research (Davies et al., 2017; Watts Pappas et al., 2016). Where our study extended this research, however, is in highlighting the value that parents place on home practice for SSD and their self-perceived role within it. Watts Pappas and her colleagues (2016) suggested that the potential short-term nature of childhood SSD may mean that parents are more willing to complete home practice for this disorder than parents of children with lifelong disabilities, some of whom find home practice to be overwhelming and incompatible with their role as a parent (e.g., Marshall & Goldbart, 2008). These different findings highlight the need for SLPs and other preschool early intervention practitioners to have open conversations with families as they commence early intervention services about each person's roles and responsibilities. Involving families in this planning process could help practitioners identify, and subsequently meet or mold, parents' expectations for intervention. This, in turn, may increase parents' satisfaction and engagement with services (Glogowska & Campbell, 2000; Lyons et al., 2010). In doing this, early intervention practitioners need to consider the dynamic nature of parents' conception of their roles and willingness to be involved in intervention (Davies et al., 2017; Watts Pappas et al., 2016). By being responsive to each family's changing expectations and wishes, early intervention practitioners can

deliver services that align with family-centered practice (Division for Early Childhood, 2014).

The parents who participated in this study spoke about their involvement in terms of managing the practicalities of home practice. Parents considered several components of this theme that influenced how they managed and completed home practice, including logistics, readiness, activities, and knowing what to do. Other parents of children with communication disorders, such as speech, language or fluency disorders, have shared similar experiences of managing activities completed at home (Goodhue et al., 2010; Thomas et al., 2017; Watts Pappas et al., 2016). These parents mentioned that they found it difficult to fit the home practice into their day, and that they sometimes forgot to complete it (Goodhue et al., 2010). The results from this study, coupled with the findings from previous research, highlight the extra responsibility and burden that home practice can place on families of children accessing preschool early intervention services. However, as the frequency of practice and completion of home practice are known to improve outcomes for children with SSD (Allen, 2013; Tosh, Arnott, & Scarinci, 2017), this added responsibility may need to be managed rather than removed for families. Managing this responsibility requires close collaboration with families to ensure that the amount, type and duration of home practice is suited to each individual family (Division for Early Childhood, 2014).

Another interesting finding from this study was that parents adapt home practice to suit their families. Parents have also been found to modify and problem-solve home practice for other early communication disorders, such as by changing where and when they complete activities (Davies et al., 2017; Goodhue et al., 2010). Adapting home practice requires a certain level of confidence on the part of parents, and the parents who participated in this study viewed their ability to modify home practice positively. Although the importance of tailored and family-friendly activities cannot be understated, the adaptation of activities needs

to be considered in terms of its possible impacts on implementation fidelity and child outcomes (Lieberman-Betz, 2015; McCormack et al., 2017). Adherence to intervention protocols, including dosage and teaching techniques, is an important component of implementation fidelity and the application of evidence-based practice. In an ideal world, SLPs (and indeed all intervention practitioners) would work with families to ensure home practice is delivered as prescribed with high fidelity. However, as the results of the present study show, the realities of delivering home practice for families of children aged 3-6 result in adaptations being made to home practice. The effectiveness of parents' adaptations to home practice for children with SSD is unknown. Practitioners are encouraged to document these adaptations so that their impacts on service effectiveness can be determined. Such documentation could contribute to practice-based evidence for involving families in home practice (Lof, 2011). By identifying family-friendly adaptations to home practice that foster positive outcomes for children and their families, practitioners could ensure that practice conducted at home positively contributes to children's outcomes.

### *Implications for Clinical Practice*

The findings from this study raise some interesting issues for SLPs, and indeed all early intervention practitioners, working with children aged 3-6 with less medically complex developmental disorders. Given the link between unmet expectations and dissatisfaction with services (Glogowska & Campbell, 2000; Lyons et al., 2010), it is important that parents' and practitioners' expectations are clearly communicated prior to the commencement of services. The results of the study reported herein suggest that this may not be occurring in everyday clinical practice. Indeed, most of the parents who participated in this study spoke of conflicts between their expectations and the realities of intervention and home practice. As previously alluded to, other researchers have identified that "families of children with less pervasive difficulties [such as SSD] may be satisfied with a more child-focused, therapist-led approach

than is suggested by family-centered practice” (Watts Pappas et al., 2016, p. 237). While the findings of the present study appear to support this assertion, it is important that SLPs and early intervention practitioners consider each individual family’s desire, willingness and readiness to be involved in completing home practice. Further, parents’ preferences for different types of home practice activities should be integrated into clinical decision-making. The current and previous studies suggest that parents’ conception of their role in home practice evolves as they experience intervention. Given the dynamic nature of parents’ experience, it is important that roles, responsibilities, and preferences are clearly discussed throughout the intervention process.

The parents who participated in this study mentioned that they were motivated by seeing their child’s progress. A similar finding has also been reported by other researchers (Goodhue et al., 2010). To harness this motivation for completing home practice, practitioners could regularly discuss and show progress to families. Example strategies to show progress include collecting and sharing data on each child’s speech skills over an intervention period, or supporting parents to reflect on changes to their child’s communicative participation. In addition, the parents who participated in this study spoke about the benefits of being provided with resources and materials to use during home practice. This benefit has also been reported by previous researchers (Watts Pappas et al., 2016); however, the current study expanded on this finding by highlighting parents’ need for clear instructions about home practice. The parents who participated in this study reported that they frequently forgot how to complete home practice activities and exactly what it was that they had been asked to do. Early intervention practitioners are thus encouraged to ensure that parents are well coached to deliver home practice (e.g. Dunst & Trivette, 2012) and provided with sufficient resources and instructions to complete practice at home.



## **Limitations**

A limitation of this study is the use of a convenience sampling strategy. Although this may have limited the diversity of experiences explored, the parents who participated in this study exhibited varied demographic characteristics (such as socioeconomic status, number of children, and work status; see Table 1).

Direct assessment of the children's speech was not possible in this study: as such it was impossible to independently verify the presence or severity of the children's SSD. However, all parents reported that their child had received intervention for SSD, suggesting that they presented with this disorder. Several parents identified that their child had been diagnosed with a concomitant communication disorder, such as stuttering or a language disorder. Given that SSD frequently co-occurs with other communication disorders (Broomfield & Dodd, 2004a), this likely reflects the clinical reality of providing home practice to children with SSD. However, the presence of a concomitant disorder may have influenced the home practice that was provided by the SLPs or each parent's experiences of completing it at home.

Another limitation is that the participants were aware that the interviewer was a certified SLP. Although the participants were assured of the confidentiality of their responses, this may have influenced the responses they provided to some questions throughout the interview.

## **Conclusions**

This study was the first to explore parents' experiences of completing home practice for their child with SSD. Parents valued home practice for SSD, and experienced an evolution in their abilities, expectations, experiences and emotions regarding completing home practice.

Although home practice was a positive experience for many parents, they identified challenges and obstacles to completing home practice, such as finding time to complete it and

knowing how to conduct the activities. Collectively, these findings speak to the complexities of this experience for families, and the need for SLPs to support families on this journey. Although these parents were interviewed about their experience with home practice for SSD, the findings are relevant to home practice for other early developmental disorders, particularly for those that may be less pervasive or medically complex (Watts Pappas et al., 2016). Practitioners working with these children and their families are encouraged to follow the Division for Early Childhood's Recommended Practices (Division for Early Childhood, 2014), and collaborate with families when planning and providing home practice.

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# PARENTS' EXPERIENCES OF HOME PRACTICE

TABLE 1. Information about participants

Parent	Child	Child's ICS <sup>a</sup> score	Speech pathology services	Other children	Education	Age	Work status	History of speech pathology intervention	Household information
Joanne	Harry (5, male)	4.3	Speech, stuttering	Ron (1, male)	PhD	35 - 44	Full-time	Received public services No longer receiving therapy	Lives with husband (Albus) and both children IRSAD <sup>c</sup> decile = 9
Jane	Darcy (6, male)	2.3	Speech, language	Elizabeth (10, female) Emma (7, female) <sup>b</sup>	Master's	35 - 44	Part-time	Darcy is currently receiving private services Family has previously accessed both public services and other private services	3 children and husband (Frederick) IRSAD decile = 9
Margaret	Jimmy (3, male)	3.0	Speech, language	none	Master's	25 - 34	Part-time	Currently receiving private services Family have also accessed public services	Husband (Glenn) and child IRSAD decile = 3
Agatha	Vera (6, female)	3.1	Speech, language	Marple (3, female)	Diploma	35 - 44	Part-time	Currently receiving services at a student-run university clinic Previously accessed public and private services	Single parent, lives with both children IRSAD decile = 4
Diana	Jamie (5, male)	3.8	Speech	Dougal (13, male) <sup>b</sup> Frank (10, male) <sup>b</sup>	Year 12 or equivalent	35 - 44	Part-time	Currently receiving services at a student-run university clinic	Husband (Roger) and three children IRSAD decile = 10
Daphne	Rebecca (4, female)	3.5	Speech	Mary (8, female)	Technical / trade	35 - 44	Homemaker	Currently receiving private services	Husband (Maximillian) and two children IRSAD = 6

<sup>a</sup>Intelligibility in Context Scale (McLeod et al., 2012a). Higher scores (maximum 5) indicate that the child is more easily understood by a range of listeners

<sup>b</sup>Child had also received, or was currently receiving, speech-language pathology intervention services

<sup>c</sup>Index of Relative Socioeconomic Advantage and Disadvantage (Australian Bureau of Statistics, 2011). Lower deciles indicate regions with relatively greater disadvantage and less advantage

Note: pseudonyms are used throughout.

## PARENTS' EXPERIENCES OF HOME PRACTICE

TABLE 2. Example of condensation of meaning unit and initial coding.

Participant	Meaning Unit	Condensed Meaning Unit	Code
Diana	I think with Jamie and how his speech is delayed, he didn't develop a friendship with people until, not much later, but until he was four, and the other kids at his group were already forming friendships with each other. They were able to play and pass toys and things like that. He [Jamie] was mistaken for snatching	My son's delayed speech meant that he didn't develop a friendship until much later than other kids	Speech impacts friendships

## PARENTS' EXPERIENCES OF HOME PRACTICE

TABLE 3. Themes and subthemes

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<b>Theme 1: Evolution over time</b>
Subtheme 1: Ability
Subtheme 2: Expectations
Subtheme 3: Experiences
Subtheme 4: Emotions
<b>Theme 2: Different roles</b>
Subtheme 1: Responsibilities
Subtheme 2: Relationships
Dimension 1: Bonds
Dimension 2: Networks
<b>Theme 3: Importance</b>
Subtheme 1: Speech is important
Subtheme 2: Parent involvement is important
Subtheme 3: Home practice is important
Subtheme 4: Rapport is important
<b>Theme 4: Managing the practicalities of home practice</b>
Subtheme 1: Logistics of home practice
Subtheme 2: Readiness
Subtheme 3: Activities
Subtheme 4: Knowing what to do

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## PARENTS' EXPERIENCES OF HOME PRACTICE

FIGURE 1

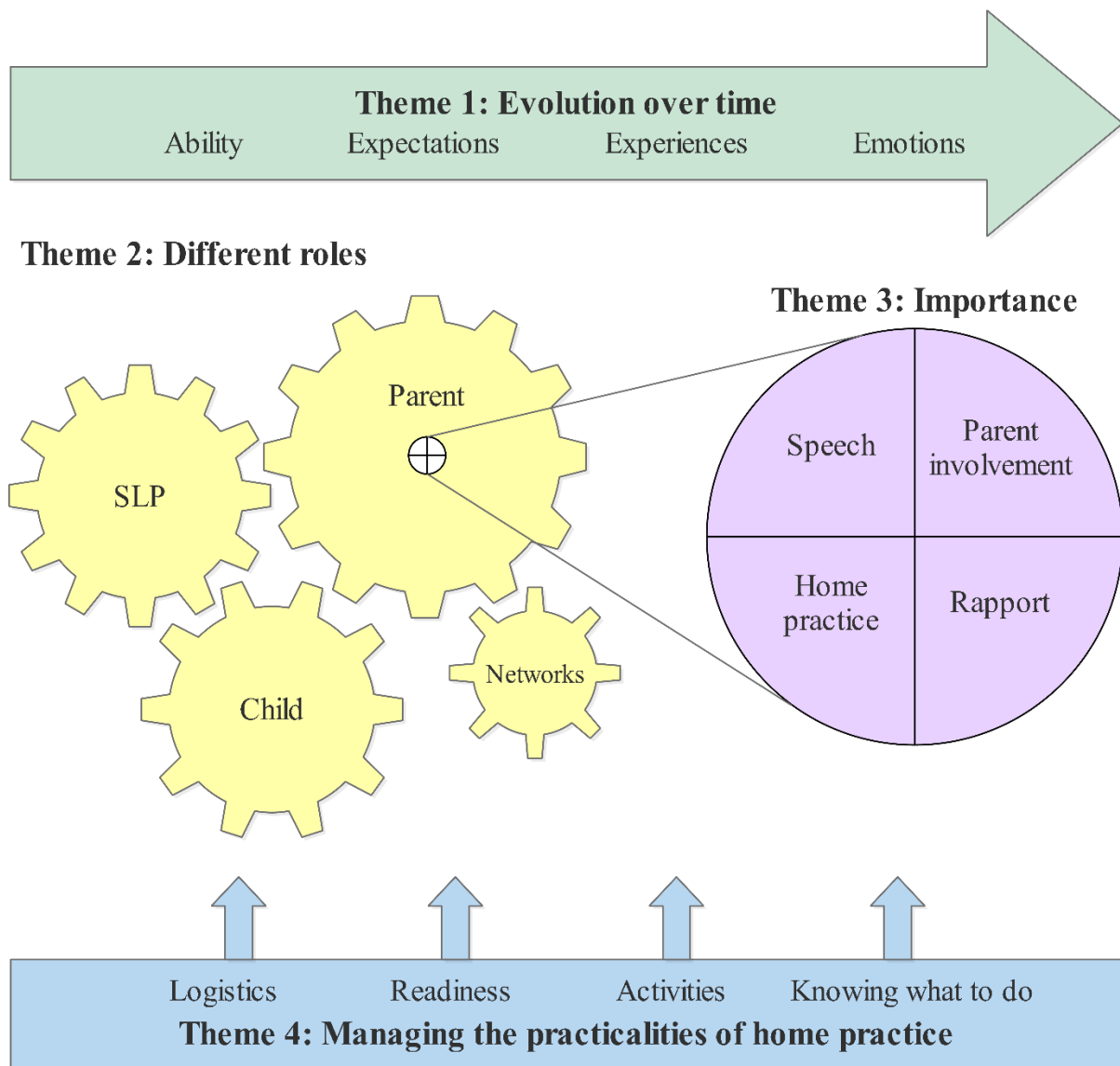


Figure 1. Relationship between themes identified in study on parents' experiences of completing home practice for children with speech sound disorders

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## Appendix A

### Interview Protocol

#### Interview Questions

The questions that I am going to ask relate to your experiences of your child's speech therapy. In particular, I'd like to hear about therapy that focused on your child's speech sounds.

1. **Opening broad question:** Speech pathologists often team up with parents to help treat speech sound disorders. Can you please tell me your experiences of this?

#### *Probe questions.*

- Were you involved in your child's intervention?
- What do you think the role of parents is in developing their child's speech?

2. **Broad question:** You said [paraphrase participant's response regarding home practice]. Can you tell me more about the home activities that you were asked to complete?

#### *Probe questions.*

- Can you give me an example of a home activity?
  - Were you asked to complete any other activities at home? Can you please describe them to me?
  - What about activities outside the home?
  - Thinking back to all of the activities that you've described, what did you think of them?
  - Do you think the activities suited you and your family?
  - What did you think of the amount of home practice activities that you were given? How did you schedule them into your day?
  - Both you and your child are integral to home practice activities. Can you tell me how your child felt about the activities?
  - Sometimes families can find doing the home activities difficult. Tell me about any challenges that you faced in doing the home activities.
3. **Broad question:** So far we have spoken about the activities your speech pathologist gave you to complete at home. I'd now like to talk about what your speech pathologist did to help you complete these activities. Can you please describe what your speech pathologist did?

#### *Probe questions.*

- A lot of the home activities can be new experiences for parents. Can you tell me about your experiences with being taught how to do the home activities?
- Do you have any suggestions for how speech pathologists could best support parents to complete the home activities?

## PARENTS' EXPERIENCES OF HOME PRACTICE

- 4. Broad question:** Pretend you are meeting a mum/dad of a child who is just starting speech therapy. What advice would you give them?

***Probe questions.***

- They specifically want to know about your experiences of doing home practice activities. What advice would you give them?

- 5. Broad question:** Overall, how would you describe the experience of doing home activities for yourself and for your child? Tell me more.

**Conclusion**

[Recap some of the responses given by the parent]

Is there anything else you would like to add that we have not yet covered?

Is there anything that you would like to ask me?

Thank you for your time and for participating in the study.